STATE CORONER'S COURT
OF NEW SOUTH WALES

Inquest:	Inquest into the death of Albert CONSTABLE
Hearing dates:	28 and 29 January 2014
Date of findings:	31 January 2014
Place of findings:	State Coroner's Court, Glebe
Findings of:	Magistrate Michael Barnes, State Coroner
Catchwords:	CORONIAL LAW – Heavy vehicle crash; momentary inattention; management of medical issues
File number:	2013/163049
Representation:	Sgt. S Harding (Advocate) assisting the coroner Mr. Jason A. Hunt appearing for Insurer of AG Constable Pty Ltd Mr. Gary Gregg appearing for Dr. Regnis

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The Coroners Act in s81(1) requires that when an inquiry is held concerning a death, the coroner must record in writing his or her findings as to various aspects of the death. These are the findings of an inquest into the death of Albert Constable.

Introduction

Shortly before 11.30pm on 23 May 2013, Albert Constable was driving a Mack Trident prime mover and towing an empty tanker trailer east on Parramatta Road Croydon. As the truck approached the intersection with Croydon Road, it suddenly swerved across the median strip and ploughed into a commercial building on the southern side of the road. Mr Constable was dead by the time paramedics arrived at the scene a short time later. He was 63 years old.

I am required to confirm that the death occurred and to make findings as to the identity of the deceased, the date, place and medical cause of the death and the manner in which it occurred.

In this case, the evidence on each of those matters is compelling and straight-forward. The inquest was convened in an endeavour to establish why the truck suddenly swerved across the road.

The evidence

Background

Mr Constable was the owner operator of a 2011 Mack Trident prime mover. He had worked in heavy vehicle transport for over 30 years. For about the last 10 years he had subcontracted to a large national company that specialised in food grade tanker trucks. This frequently involved him collecting a tanker trailer from a yard in Prestons, driving to Glebe Island transport terminal to have the tanker filled, and then delivering the load to one of various centres throughout NSW or interstate.

Mr Constable lived at Taro near Newcastle with his wife and her two daughters. He returned home whenever his work allowed which at the relevant time was usually a few nights per week.

On the day before the crash he slept in the truck overnight at Calga and arrived home mid morning. After washing the truck he went to bed at about 11.30am. When his wife arrived home at about 5.40pm he told her he had only recently arisen. He went back to bed an hour or so later but could not sleep, and so told his wife he would go and collect a tanker trailer, drive to Glebe Island and sleep there overnight.

He left home at about 8.30pm.

The crash

After collecting a tanker trailer from Prestons, Mr Constable made for Glebe Island via the M4 freeway. He then turned onto Parramatta Road which at this point has three lanes in each direction separated by a median strip. Travelling in an easterly direction he approached Croydon shortly before 11.30pm.

A number of motorists who saw the truck in the seconds before it crashed were identified and gave statements that were included in the brief. Some also gave oral evidence at the inquest. All agreed that it had been raining throughout the night, although the consensus seems to be that it was not actually raining at the time of the crash.

Salvatore Panaterri, who was travelling in the same direction, says that he came upon the truck soon after the two vehicles left the M4. He says that as they proceeded in-bound along Parramatta Road the truck was moving in and out of the middle lane causing him to refrain from overtaking it.

As a result of viewing vision recorded on a dashboard-mounted camera, I am satisfied that this driving was not due to any lack of control by Mr Constable. Rather, it appears to me he was taking advantage of the very light traffic flow to utilize more than one lane when negotiating curves in the road. On straight sections the truck can be seen to be fully within the centre lane and travelling in a steady and controlled manner.

Batuary Akin was also travelling in-bound on Parramatta Road at about this time. He was stopped at traffic control lights at the intersection Arlington Street on the left and Croydon Road on the right. He was in the lane closest to the median strip, other vehicles were occupying the two other lanes. When the light changed to green he began to move off and just as he did so he heard a loud bang which caused him to look in his rear-view mirror. He says he saw close behind him a large truck which veered to its right and crossed over the median strip and the three outbound lanes before it crashed into a commercial building on the corner of Parramatta Road and Croydon Road.

Mr Akin's evidence was somewhat inconsistent on the point, but I understand the effect of it to be that he heard no sounds of braking or anything else until he heard the bang and that when he looked back the truck had already mounted the median strip causing him to conclude the sound had been made by it doing so.

Helen Barlas was also driving east on Parramatta Road at about this time. She came up behind the truck a few hundred metres before the crash. She observed nothing unusual or inappropriate about the manner in which the vehicle was being driven.

As Ms Barlas crested a slight rise approximately two hundred metres west of the crash scene she saw traffic control lights in the distance that she thought were green green. She followed a few car lengths behind the truck as they approached that intersection. Suddenly, and without warning, the truck swung to the right and Ms Barlas watched as it proceeded across the out-bound lanes and crashed into the building as described by Mr Akin. She said in her statement and was adamant in her oral evidence that before the truck left the in-bound lanes she saw its brake lights illuminate a number of times.

There were also vehicles travelling outbound on Parramatta Road that were stationary at the same set of traffic lights. One of them was a semi-trailer driven by Peter Frewen. He was in the centre lane, one car back from the stop line. There were cars in the lanes on each side of his vehicle.

Mr. Frewen's attention was first drawn to the truck driven by Mr. Constable when he noticed its bonnet "*leap into the air*" as it mounted the median strip.

Mr. Frewen was initially of the opinion that the truck was "*jack knifing*" – a loss of control that results in the trailer moving in a different direction to the prime mover. He then noticed that the drive wheels on the prime mover were still rotating and that the trailer was following a similar line of travel to the prime mover. This led him to conclude that the truck's driver had not lost control due to excessive braking.

He expanded upon this at the inquest and expressed the firm view that the truck was intentionally driven across the median strip under the control of its driver.

Mr. Frewen assumed that this was done to avoid the truck colliding with the vehicles that were stationary at the stoplight facing the Mack truck. He could not explain why after crossing the median strip the driver of the truck did not appear to make any effort to straighten the path of travel so as to avoid crashing into the building, which is what he saw happen next.

Colin Stevenson was parking a bus in Arlington Street near its intersection with Parramatta Road.

In his statement he said, "*I heard the heavy breaking of a truck".* In evidence, he revised that to say that he heard the revving of a truck engine and that it may have been engagement of the clutch, which drew his attention rather than braking.

In any event, immediately after hearing the noise, he saw the truck we now know was being driven by Mr. Constable, veer to its right, out of the middle lane, across the median strip and crash into the building. He was sure that as it undertook that manoeuvre, the driver wasn't using the brakes.

The aftermath

As soon as the crash occurred Mr. Frewen activated his hazard lights, got out of his truck and ran to the crash scene. He saw smoke and steam coming out of the front of the truck, which was penetrating into the building as far as the back of the cabin.

Without regard for his own safety, Mr Frewen first opened the passenger door and when he could not reach the driver he climbed under the tanker trailer and went to the driver's side. The door had come off the sleeper compartment and so he climbed up into that position but still couldn't see the driver. He again tried to gain entry through the passenger door but as he was doing so emergency services crews began arriving and the area was quickly cleared of people.

Mr. Stevenson immediately called '000' and advised of the crash. A tow-truck driver whose business abutted Arlington Street immediately ran one of his vehicles across Parramatta Road to stop the traffic. Workers from the hotel on the corner of Arlington Street and Parramatta Road ran over to see if they could assist.

Emergency crews of fire and rescue and ambulance officers quickly arrived at the scene. Two ambulance officers climbed up into the driver's side of the truck cabin.

They were unable to see the driver but after a short time they were able to reach through the debris and make manual contact with him. One of the ambulance officers was able to palpate the driver's neck area but was unable to locate any pulse or other signs of life. Mr. Constable was unresponsive to verbal interaction. The ambulance officers formed the view that the driver was deceased.

A short time later emergency crews concerned by noises the truck was making, the smell of leaking gas and arcing electrical wiring became concerned that an explosion may occur and moved all personnel away from the wreck.

The building had to be stabilised before the truck could be pulled from the wreckage. This was accomplished shortly before 6.00am.

Mr Constable's body was able to be removed from the vehicle an hour later. He was formally identified by a work colleague who had known him for nine years.

The investigation

At about 11:40pm Constable Benjamin Bickle and his partner arrived at the scene and commenced the investigation of the incident. Constable Bickle provided a report that formed the basis of the evidence for the inquest.

Scene Inspection

Constable Bickle examined the scene. He found the area to be well lit and while the road was wet, it seemed it had not been raining at the time of the crash.

The road consisted of 6 lanes- 3 travelling in each direction. It was in total, 17.92 metres wide and was in reasonable condition.

He caused photographs to be taken of the area and of the wreckage.

Constable Bickle examined the road and could find no skid marks, although he believes that dry tyre tracks leading from the inbound lanes across the outbound lanes to the rear of the vehicle were made by the truck.

He observed the truck to be protruding from the building on the corner of Parramatta Road and Croydon Road. The cabin of the vehicle was extensively damaged and he could not see into the driver's compartment. He did note that the roof of the vehicle was badly crushed and forced downward into what would have been the part of the cabin occupied by the driver.

There was a large amount of concrete and metal debris also within that driver's section. When he looked into the cabin from the sleeper section he could see that the driver's seat was pushed back at an angle of about 60 degrees and that on both side's of the driver seat there was torn metal and broken plastic making it impossible to enter or see the driver.

Constable Bickle impounded the vehicle and had it taken to the holding yard where it was examined by a NSW Police Force Mechanical Inspector.

A dash-mounted digital camera and the driver's heavy vehicle log books were seized as were seven medication prescriptions in Mr Constable's name that were found in the truck. The material recorded on the camera was downloaded and the doctor who had issued the prescriptions, Dr Jeff Regnis, was interviewed and his records of his treatment of Mr Constable were obtained.

A review of the vision recorded on the Navman dash-mount camera shows the journey taken by Mr Constable after leaving his home at about 8:30pm. It shows him driving normally, stopping at traffic lights as and when required. It also shows that the traffic lights at the crash scene turn red when the truck is about 200 metres west of that location. The truck can be seen to be continuing to travel in that direction maintaining its speed without any apparent attempt to slow as it approaches the intersection where a number of vehicles are stopped at the traffic lights. About 30 meters from the intersection the truck suddenly veers right and crashes into the building causing the recording to cease.

Constable Bickle took possession of and had down loaded the CCTV footage from a camera mounted on the Illinois Hotel situated on the corner of Parramatta Road and Arlington Street. It showed traffic flowing in an easterly direction along Parramatta Road through the intersection.

Relevantly, the CCTV footage from the Illinois Hotel camera shows the traffic control lights facing east-bound traffic on Parramatta Road turn red 25 seconds before the crash.

Autopsy results

On 27 May 2013, an autopsy was undertaken on Mr Constable's body by Dr Pokorny, a pathology registrar, under the supervision of Dr Rebecca Irvine, experienced forensic pathologist. The examination revealed multiple blunt force injuries to the head and upper body. A large scalp laceration suggested a significant impact to the head, although no traumatic injury to the brain was seen.

The autopsy also found features suggestive of mechanical asphyxia, namely band-like injuries to Mr. Constable's chest, and petechial haemmorrhages in the eyelids. These were significant in a setting where the deceased had been found in the crushed cabin of his truck.

There was also evidence of atherosclerotic narrowing in the coronary arteries, but no acute ischaemic changes were identified. However, as with the absence of evidence of a brain injury this really only indicates there had been no previous ischaemic events.

Based on all of the evidence, the pathologist concluded: "*on the balance of probabilities in my opinion the cause of death is best given as the combined effects of multiple blunt force injuries and mechanical asphyxia*".

Mechanical inspection

On 27 May 2013, Senior Constable Anthony Pellicane of the NSW Police Engineering Investigation Section undertook a forensic mechanical examination to determine if a mechanical failure or defect may have contributed to the fatal crash of

the truck being driven by Mr Constable. The examination included testing the breaks where possible, and examining the steering and suspension, the wheels and the tires.

As a result of the examination Senior Constable Pellicane concluded that there were: *"no mechanical defects or component failure which may have contributed to the collision occurring."* Further, he reported *"all of the damage detected on the truck and trailer was consistent with damage from the collision."*

Medical issues

Mr Constable had a number of medical issues that had the potential to negatively impact on his ability to drive safely. He had for many years been treated by Dr Jeff Regnis who told the inquest that they had established a therapeutic alliance that gave him a basis to be confident that Mr Constable would be frank with him about his symptoms and health issues. I shall deal with each of the relevant matters in sequence.

Depression

Mr. Constable had a long history of depression probably springing from an unhappy childhood and an unsuccessful first marriage. In May 2008, following conflict with his step-daughter, against a setting of financial pressure from the business, he attempted suicide. As a result, he was put on a number of anti-depressants. The first medication provided caused him drowsiness so it was discontinued. A second drug was used for a period but it apparently made him anxious. Therefore in 2006, he was switched to Avanza, 30mg per day.

In February 2013, Dr Regnis provided him a new prescription for the drug along with five repeats. The prescriptions found in his truck after the crash indicate that a few weeks before the crash, only the second of those prescriptions was filled, suggesting Mr Constable had not been taking Avanza at the prescribed rate. His wife confirmed this. She said he habitually decanted his medications into a dispensing pack each week on Sunday evening. As a result of watching her husband do this, Ms Constable was aware that more than six months before his death, Mr Constable had adopted the practice of halving the dose of Avanza by splitting the tablets in two.

Dr Regnis said that on his last consultation with Mr Constable in March 2013, the patient was bright and future orientated. He had no symptoms of depression. He is confident Mr Constable would have told him were he troubled. This is also confirmed by his wife who says her husband was in a positive frame of mind in the weeks before his death.

I conclude Mr Constable's depression was being adequately managed.

Hypertension

Mr. Constable had been diagnosed with and was being treated for hypertension. Dr Regnis gave evidence that at the last consultation Mr Constable's blood pressure was only slightly above the target range. Although the autopsy revealed significant occlusion of his coronary arteries, there was no basis to conclude hypertension or the atherosclerotic changes caused an acute cardiac event. Mr Constable had not

suffered any such symptoms in the past and he was being appropriately treated at the time of his death.

I conclude this condition provides no insight into the manner of his death

Diabetes

In the mid 1990s Mr. Constable was diagnosed with Type II Diabetes and for an extended period this was not well managed. However, from about the beginning of this decade, it seems he began to take a more responsible approach to the disease. Rather than living in his truck five days a week, his routine was varied so he'd spend more time at home and Mr Constable appeared to accept advice that he needed to make lifestyle changes.

Under the guidance of an endocrinologist and his general practitioner, Mr Constable lost about 3 kilograms in weight and accepted the importance of having regular meals and a balanced diet.

A report dated 11 April 2011 recites that he had not suffered from hypoglycaemia at any stage. This was confirmed by his wife and his GP who told the court that Mr Constable was cognisant of the symptoms of hypoglycaemia and was aware of the steps he had to take to avoid it.

He was prescribed a number of medications to assist with the control of his diabetes and according to his wife and his doctor he was medication compliant. Although only one of the medications prescribed for Mr Constable's diabetes was detected by toxicology post mortem screening, there is no evidence that he was not taking the other prescribed medications.

Glycated hemoglobin - or HbA1c - is measured to identify the average plasma glucose concentration in a patient's blood over prolonged periods of time. Mr Constable's HbA1c had been as high as 15. The target range was below 7. When he was last tested in March 2013 it was 7.7.

Dr Regnis said in his initial statement that Mr. Constable had "*poorly controlled Type II diabetes and hypertension*". At the inquest he said that was probably an unduly harsh assessment and referred only to the fact that his HbA1c and systolic blood pressure were slightly above the desired ranges.

His wife also told the court that Mr Constable had told her of an occasion when he was driving a truck out of Melbourne and he became aware of a hyperglycaemic episode and drove himself to the hospital for treatment. This is consistent with Dr Regnis' view that Mr Constable had insight to his illness, knew the steps to take to avoid them and to respond to them if necessary.

I conclude that Mr Constable's diabetes was being well-managed

Fatigue management

The investigator reviewed the deceased's driving log-book. It showed that six days before the fatal crash, on 17 May 2013, Mr Constable did not drive at all. In the ensuing five days he drove a total of just under 4000 kms and on average rested, or

at least was not driving, for 12 hours each day. On the day of the crash Mr Constable had been out of the truck for about 7 hours before driving only 80 kms from his home near Newcastle.

Ms Constable said her husband was very fastidious about complying with fatigue management obligations, as was the company they contracted with. She said in evidence a 2011 conviction for breaching those regulations was the result of an administrative error only. Her observations are borne out by Mr Constable spending the night before the crash sleeping at Calga. He did so because he had reached his 14 hour driving limit, even though his home was only some 60 kms further up the highway.

Conclusions

The only aspect of this sad death that was in contention is why did the truck Mr Constable was driving suddenly swerve onto the wrong side of the road and crash into a building.

The truck was relatively new and in good working order. An inspection found no mechanical fault that could have contributed to the crash. No other vehicle interacted with Mr Constable's truck causing it to crash.

Mr Constable suffered from a number of ailments that could potentially have precipitated a crash if they had manifested acutely at an inopportune time. The legal representative of the company which insured the truck submitted that this theoretical possibility became a probable explanation because the sudden deviation in the truck's path of travel could have been caused by the driver collapsing and pulling the steering wheel to the right as he slumped in his seat.

In my view this analysis is flawed for a variety of reasons.

First, as detailed in my summary of the evidence, I am satisfied that none of the ailments from which Mr Constable suffered were so poorly managed that they were likely to become suddenly acute. His diabetes and hypertension were being actively and successfully treated. He had regular medical examinations as mandated by the Road Transport Authority and his employer. Each of those concluded he was fit to drive

Further, Mr Constable had never suffered from hypoglycaemia – the most likely deterioration of his known illnesses which could have hampered driving. In any event he knew the symptoms and how to respond to them. He had once previously had a hyperglycaemic episode but he recognised that was occurring and took appropriate steps to respond to it. In addition, there is no evidence that hyperglycaemia is likely to cause a sudden loss of consciousness or incapacity.

Because of all of his circumstances, Mr Constable did have an elevated risk of a sudden cardiac event, but a bare possibility of an event occurring is not a sound basis for making a finding that it eventuated when there are other more compelling explanations.

The truck did not slowly drift out of its lane. It turned sharply at approximately 45 degrees to its original line of travel. Constable Bickle told the inquest that such a significant change of direction would have required the steering wheel to be moved through more than a complete revolution. That could not occur by accident or as the result of an involuntary movement of the driver.

In my view the manner in which the truck suddenly left its path of travel after being, just before it collided with the cars stationary at the intersection, make it far more likely that was the result of a deliberate action.

Suicide was raised as a possibility because of the absence of any indication that the driver had tried to avoid the collision with the building and Mr Constable had previously made a documented attempt on his life.

However, I am readily persuaded that even were Mr Constable inclined to take his own life, the circumstances of this crash are not consistent with a deliberate attempt to do so. Just a short time before the crash he had been on the open road where opportunities for a deliberately fatal collision were abundant. That this relatively low speed crash ended his life was very unfortunate and unforseen, in my view. Further, there was another reason for the sudden change of direction that was not connected to any wish for self-harm, namely the desire to avoid colliding with the other vehicles in front of the truck. The chances of those two motives coinciding are very slight. In addition, all of the evidence indicates Mr Constable was taking prescribed anti-depressant medication and that it was effective. There is no evidence that he was contemplating ending his life.

I dismiss suicide as a manner of death.

It is far more likely in my view that for some reason Mr Constable did not appreciate that there were cars stopped at the intersection until he was too close to them to safely stop without a collision. He then took the brave, honourable but dangerous course of swerving to the wrong side of the road so that the safety of the innocent occupants of those vehicles would not be jeopardised by his actions. Why that became necessary is difficult to ascertain.

If Mr Constable's log-book entries are accurate, and I have no reason to doubt them, fatigue played no part in the crash. He had rested for some seven hours on the day in question and had only driven 80 kms from his home before the crash occurred.

The traffic lights which caused the cars at risk to stop had been red for 25 seconds when the crash occurred but the intersection only became visible to Mr Constable when he came over the crest of a hill some 170 - 200 metres west of the crash scene. Travelling at 60kms per hour it would take 10 to12 seconds to cover that distance.

There is evidence that Mr Constable tried to brake and perhaps to change to a lower gear shortly before he swerved, when about 30 metres west of the intersection. Assuming those futile attempts to slow the vehicle occurred while it travelled over another 30 - 40 metres, it means that for about 100 - 140 metres of travel the driver failed to appreciate that the road ahead was blocked by traffic – a distance that

would have been covered in 6 to 8 seconds – when careful observation would have made this apparent.

The topography and built environment were by no means favourable: the road traverses a moderate right hand bend just as it crests a hill; it then runs downhill at a moderately steep grade to the intersection, before again bending to the right and climbing another rise. From the top of the hill approaching the crash site on a wet night, a driver is faced with a myriad of light sources, at various distances, some super imposed over others with the road beyond the crash site clearly visible.

Initially, Mr Constable continued straight down that part of the road in a controlled and appropriate fashion and so he was obviously largely aware of his circumstances. His failing to see and respond to the red light at the bottom of the hill only required that he not focus on the middle distance for a few seconds.

It is easy to accept that he was distracted by something within the cabin of his truck that took his attention. He could in those circumstances rely on his peripheral vision to keep the truck within its lane while not paying sufficient attention to what was up ahead that might require definitive action.

When he became aware of the situation he took the only action he could conceive in that instant to save those he risked harming. In the following second or two as the truck careered across the road he was unable regain control or stop the truck before it crashed into the building.

Findings required by s81(1)

As a result of considering all of the documentary evidence and the oral evidence given at the inquest, I am able to confirm that the death occurred and make the following findings in relation to it.

The identity of the deceased

The person who died in the crash was Albert CONSTABLE.

Date of death

Mr Constable died on 23 May 2013.

Place of death

He died at Croydon, NSW

Cause of death

The death resulted from blunt force injuries and mechanical asphyxia.

Manner of death

Mr Constable died when the truck he was driving crossed to the incorrect side of the road and collided with a commercial building crushing the truck's cabin and fatally injuring the driver. It is most likely the driver was forced to swerve across the road as a result of momentary inattention causing him to fail to notice stationary vehicles in front of him until he was too close to them to stop without colliding with them.

I close this inquiry.

M A Barnes
NSW State Coroner
Glebe
31 January 2014